GROUP RECOMMENDATIONS ON THE DHMH SEVEN PRINCIPLES OF BEHAVIORAL HEALTH INTEGRATION

Governor's Mental Health Advisory Council

GROUP 1

PRINCIPLE 1 – **Individuals and Families should be able to access the right services at the right time to remain as healthy and productive as possible.**

Group Discussion Points:

Opportunities to Preserve:

- Present system allows easy access – Cadillac of systems, broad range of services
- Consumer choice
- Robust consumer, youth, and family involvement
- Partnering with advocacy groups
- Local input on development of services. Each area allowed to develop services appropriate to its region.
- Use of peer support in all areas of managed care
- PEP delivers services to deaf/hard of hearing
- Utilization of SEC
- Tracking outcomes and trends in an integrated system
- Continue to Share to spread information
- Services for special pops such as vets, criminal justice, TBI, etc.
- Minimal paperwork or "hoop jumping unlike some other states
- Medicaid waivers
- Availability of any willing/qualified provider
- EBPs for variety of categories
- Provision of specialized treatment rather than "one size fits all"
- Importance of having CSAs and ASO that are mental health specific

Opportunities to Improve:

- Who will ultimately monitor accountability to ensure people are accessing right services at the right time beyond just the regulations?
- Continue to Share to spread information
- Integrated advocacy – partner with ADAA to have integrated BH advocacy.
- Integrated regulations to increase universal access
- Access and utilization of somatic services
- Continue to explore more variety of services for individuals with multiple needs – flexibility
- Additional funding for person-centered care
- Assuring all changes coincide with Health Care Reform
- Consideration of Health Home concept

Group Recommendations:

- Integration should be in line with Whole Health Model
- Consumer driven system that prioritizes an increasing use of advocacy and peer support
- Leverage technology to enhance universal access:
    - Use of language (culturally competence)
    - Effective use of data and data outcomes
    - The use of all services
- Accountable, state of the art system that ensure universal access to timely and quality services

GROUP 2

PRINCIPLE 2 – **A new system should support effective models of Integrated Care [across the life span].**

Group Discussion Points:

Points to consider as System makes changes:

- Recognition that each segment has special needs
- Even definitions/diagnoses between child world and adult world very different
- Wondering if there is a need to have two health homes for child and adult because coordination of services may be very different
- Prevention across life span important. Older adults certainly benefit from earlier identification

Core requirements of Integrated Model/Opportunities to Preserve:

- Providers – increased knowledge/awareness
- Consumer choice – families/youth have a voice
- Consumer Quality Team – statewide expansion
- Insured access without profit motive – no denials
- Expanded use of Navigators who understand specific populations (CSAs really do this now on the local level. (OOOMD receiving SAMHSA funding for Navigators – consumer run programs to be trained in ACA through initial Statewide Summit on September 20th
- Self directed care – will add Baltimore City individuals who are homeless or high end
- Value of diversion – use of incentives or awards system for low hospital admissions
- System should be set up so that recovery is also an incentive
- Access to community-based services
- Flexibility and availability of levels of care – easily adaptable as life circumstances (age, income, recovery) change

Opportunities to Improve:

- True integrated care – mental health, substance use, somatic, not silos – shared care plans, records
- CQT needed in Health Homes
- As CQT expands must focus on children and families
- Perhaps in future diversion can include a metrix/pay for performance system

Group Recommendations:

- Modify the principle to include across the lifespan

- Maintain and increase access to services and consumer and family choice
    - Look at depth and breadth (elements including interest and locality) of potential resources

- Facilitate navigation
    - Adjust as life circumstances change (age, income, recovery)
    - Compliment resources of system-based and peer/family-based
    - CSAs, peer advocates, Wellness and Recovery Centers

- Education and incentivization issues for consumers, families, natural supports, and other clinicians/systems outside of "PMHS" diversion, self-directed care, WRAP, etc.

- Continued emphasis on community based services

GROUP 3

PRINCIPLES 3 & 4

A new system should prioritize the needs of seriously ill. Special attention must be paid to assure coordinated care for especially vulnerable Marylanders who experience severe mental illness and substance abuse disorders.

A new system should integrate financing for substance abuse and mental health treatment services.

Group Discussion Points:

Opportunities to Preserve:

- Peer Specialists and peer support
- Simplified system of payment for all services provided

Opportunities to Improve:

- Enhanced care coordination
- Improved system navigation
- Eliminate processes that impede optimum care

Group Recommendations:

- Maintain oversight and management at the local level
- Review and evaluate processes of coordination of care
- Utilize evidence-based tools/process (i.e. NIATx, COMPASS)

- Identify, support and implement one EHR
    - Accurate data
    - Streamline services
    - Best practices

- Streamline the billing system
    - CPT codes,
    - Financial and benefits coordination
    - Comprehensive health Navigation

- Workforce development – focus on educating providers, trauma-care awareness (Stigma reduction), no wrong door policy, Certification/Credential; ACA (increased reimbursement)

GROUP 4

PRINCIPLE 5 – A new system should provide payment on the basis of performance, value and outcome, and not just volume.

Group Discussion Points:

Core Requirements/Opportunities to Preserve:

- Pay for Performance = outcomes, outcomes
- Population among most challenging – process and outcome measurements important and helpful.
- Need to understand formulas for emerging outcomes
- BH has great value for sharing expertise regarding the challenging populations
- Must capture important data and ability to have appropriate access to it – data repository
- Concerns about information exchange and confidentiality – maybe some data collection on people using step down services without including hospital admission info could be useful
- Frederick County hospital with MIMS data collection and implications for high end costs – suggested model.
- To be most effective, data should be collected on quality of life issues – where people live and go
- Behavioral health programs/services can be expensive
- Good quality is good business and premise should be standard
- Possibility that with MA expansion benefits may shift, become more limited
- Services deriving from Health Departments have special challenges:
    - Interface with hospital systems
    - Payment/insurance issues
    - Claims system may not capture special measures for BH needs
    - Providers in competition
    - Paying dearly for chronically underfunded services

Opportunities to Improve:

- Whole person care as a model
- Perception that Maryland is behind some states regarding integration and standards (MO, MI, NY)
- Increased use of technology – telemedicine, smartphones, apps, ability to go on-line for groups
- Need more resources at step down levels. Need more step down levels
- Use consumer/peer specialists (peer certification movement) to enhance continuum of care

- Suggestion of looking at process/outcomes for 5 major diagnoses and develop matrix with milestones expected

Group Recommendations:

- Create and develop a matrix of process and outcomes that can be measured.

- Retain access to data, as well as expand to include an integrated model that includes substance use and somatic care as a basis for payment for performance

- Funded continuum of care and look at quality of care at each level and identify gaps, assign cost value and value of services.

- Build on experience learned in evolution of health home and ensure that overall health care savings are shared by Behavioral Health system and primary care.

GROUP 5

PRINCIPLE 6-**A new system should include a strong role for local oversight and engagement. The financing system should provide comprehensive service and outcome data to localities.**

Group Discussion Points:

Core Requirements/Opportunities to Preserve:

- Access to appropriate level of information (legal, individual versus aggregate)
- Utilize "end user" (consumer, youth, family member) feedback – progress services, CQT, consumer surveys
- Data set defined by key stakeholders based on what is important or useful

Principles for Choosing Data:

- Helpful to consumers
- Efficiency
- Accessibility
- Redundancy (consistency?)
- Burden
- Utility
- Prevention of historical data loss
- Fully supporting full continuum of care
- Ability to link with data of other systems
- Match with SAMHSA standards and other reporting requirements
- Content match with integration
- Balancing system-provider-population needs
- Appropriate use and interpretation (case mgt., socioeconomic contexts) – guidance and limits provided
- Real time/timely feedback

Opportunities to Improve:

- Appropriate resources to collect analyze, and disseminate data – content analysis
- Clarification of what is and is not protected
- Use of historical data to define local entity oversight and roles
- Defining and refining promotion of resilience and recovery

Group Recommendations:

- Building on existing resources – filling gaps. Data should be defined by key stakeholders as meaningful and including above principles

- Data should reflect content for behavioral and somatic integration.

- Data needs to be linked to partner systems/agencies:
  - Criminal Justice
  - Juvenile justice
  - Housing
  - Education
  - Child welfare

- Mandate submission of data by authorities that have power to enforce and follow-through

- Data is timely and accessible to stake holders. Adequate resources available to:
  - Analyze
  - Interpret
  - Disseminate data
  - Guidance provided to assist in data utilization, interpretation, and use in quality improvement and technical assistance.

GROUP 6

PRINCIPLE 7 – **A new system should be able to coordinate well with other systems, including criminal justice, education, and child welfare systems, to promote social outcomes such as successful community reintegration, adoptions and permanent placements, school achievement and others.**

Group Discussion Points:

Core Requirements/Opportunities to Preserve:

- Care coordination across systems for children and adolescents, avoidance of ill-fated referrals
- Funding across systems for children and adolescents
- Funding streams established that protect access
- "Chronic Disease Management" – Office of Aging's evidence – based practice
- A more "robust" Crisis System across the life span
- Interoperation of data systems
- Use of cross data measures
- Cross data tracking across adult and child systems:
  - Publicly insured
  - Uninsured
  - Privately insured
- Awareness of "digital gap" – language differences and inaccessibility to computer/internet

Opportunities to Improve:

- Interagency coordination at the leadership level does not often translate throughout the systems, particularly sharing of information.
- How to deal with multiple information and referral (I&R) sources – how to identify reliable I&R sources – must be reliable and accurate
- How to track outcomes, such as recidivism, in all systems?
- How to bridge the TAY gap in cross data tracking
- Looking at peer issues that complicate substance use and mental health treatment

Group Recommendations:

- recognize common principles – Care coordination and funding across systems and life span
- Increase awareness of needs of individuals across the life span and ensure that people have access to specialty services. Make sure that our provider network is included in new system process and funding is preserved (services such as crisis response systems).
- Specialty needs of citizens aging in place, specialty transition services are available/maintained.
- Data sets in other systems need to be coordinated to gain a full picture (outcomes, funding streams etc.) – What are the shared outcomes/aims across systems
- Resource network process
- Training across systems/workforce development
- All efforts to mitigate the negative consequences of change. – Information sharing group among providers